

## DONATION FORM

This form can be printed and mailed to:

**The Hauptman-Woodward Medical Research Institute**  
**Director of Development**  
**700 Ellicott Street**  
**Buffalo, NY 14203-1102**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Phone: \_\_\_\_\_

- \$1000 Hauptman Society Member  
 \$500    \$250    \$100    \$50    \$25    Other \_\_\_\_\_

Visa Card       MasterCard       Check       Cash

Card Holder's Name: \_\_\_\_\_

Card Number : \_\_\_\_\_

Amount \$ \_\_\_\_\_ Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_

*(Required for credit card transactions)*

*Please make checks payable to: Hauptman-Woodward Institute*

*My employer will match my gift. Please contact me.*

### **Please complete if this contribution is:**

In memory of: \_\_\_\_\_

In Honor of/Special Occasion: \_\_\_\_\_

### **Please Notify:**

Name: \_\_\_\_\_

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